STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120965-001-SF**

BCN Service Company
Respondent

Issued and entered
this 20th day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 27, 2011, XXXXX, on behalf of her minor daughter XXXXX (Petitioner), filed a request with the Commissioner of Financial and Insurance Regulation for an external review under Section 2(1)(b) of Public Act No. 495 of 2006, MCL 550.1952(1)(b).

The Petitioner receives group health care benefits under a self-funded plan through the XXXXX Michigan, a local unit of government as defined in Section 1 of Act 495, MCL 550.1951. The health plan provides benefits for employees of the University and their dependents, and is administered by BCN Service Company (BCNSC), a third party administrator and the contracting entity under Section 2(1) of Act 495, MCL 550.1952(1).

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*.

The Commissioner immediately notified BCNSC of the request for external review and asked for the information it used to make its final adverse determination. The Commissioner received BCNSC's initial response on April 29, 2011.

On May 4, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request. On May 9, 2011, BCNSC provided additional information.

The issue in this external review can be decided by a contractual analysis. The contract here is the "U-M Premier Care Benefit Document 2010" (the benefit document) which defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under PRIRA pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner, born XXXXX, was diagnosed with juvenile scoliosis and required a corrective back brace to treat her condition. On June 2, 2010, she was fitted with a SpineCor brace at the XXXXX Care Center (XXXXX) in XXXXX, XXXXX. XXXXX is not in the health plan's provider network.

The Petitioner's mother paid XXXXX $4,570.00 for the brace and then requested authorization and reimbursement from BCNSC. BCNSC denied the request on the basis that service from a non-network provider is not covered without prior authorization.

The Petitioner's mother appealed the denial through BCNSC's internal grievance process. At its conclusion, BCNSC affirmed its decision and issued its final adverse determination dated February 25, 2011.

III. ISSUE

Did BCNSC properly deny coverage for the Petitioner's brace?

IV. ANALYSIS

Petitioner's Argument

The Petitioner's mother states she bought the brace at XXXXX because BCNSC's medical supplier told her there were no network providers who specialize in the SpineCor brace. She learned that XXXXX specialized in fitting the SpineCor brace and made an appointment for the Petitioner. She states she believed BCNSC would cover the brace because it was medically necessary.[1]

Respondent's Argument

In its February 25, 2011, final adverse determination BCNSC advised the Petitioner:

> [T]he [grievance] Panel denied your request for the durable medical equipment obtained out of network; you did not have authorization for the item.

1 There is no dispute here that the brace was medically necessary.

Commissioner's Review

The benefit document contains the following provision in "Section 9: Exclusions and Limitations" (p. 50):

> ***9.17 Unauthorized and Out-of-Plan Services***
>
> Except for emergency and urgent care [2] as specified in Section 8.6 of this booklet, health, medical and hospital services listed in this Benefit Document are covered only if they are:
>
> - Provided by a U-M Premier Care Network 1 or Network 2 affiliated provider; or
> - Preauthorized by BCN.
>
> Any other services will not be paid for by BCN either to the provider or the Member.

There is no dispute in this record that the Petitioner received services from a non-network provider without authorization and the Petitioner does not assert otherwise. The Petitioner's mother does believe she was justified in going to XXXXX for the brace as she explained in her request for external review:

> [BCNSC] sends their orthotic and DME (Durable Medical Equipment) claims through XXXXX. When I called XXXXX, I was told that the SpineCor Brace was NOT covered. The only brace that would be covered was the "hard" brace and my daughter's curvature had to be at 30 degrees to qualify; at that time, she was at 24 degrees. So, in effect, she had to get worse before she would qualify.
>
> I researched online and found [a doctor who] was a leading expert in fitting the SpineCor Brace. I made an appointment and traveled to XXXXX where my daughter . . . was fitted with the brace. This was in June, 2010.
>
> [The] office manager . . . (of XXXXX Centers) also called XXXXX to inquire whether they would cover the brace and was told there was no one "in network" that handled the SpineCor Brace.
>
> Therefore, we went out of network in order to obtain the SpineCor Brace for our daughter, believing we would be reimbursed when we provided proof that the brace was medically necessary.
>
> The brace has been deemed "medically necessary" by [the Petitioner's] orthopedist . . .

2 The Petitioner has not claimed that emergency or urgent care was received from XXXXX and the record would not support such a finding.

> I provided the above information to [BCNSC] and asked for reimbursement of the brace, which cost $4570, but was denied because I went out of network! Thus began the argument of what I was told from the beginning that [BCNSC] did not have an "in network" provider for this brace.
>
> I am very disappointed in XXXXX because I feel they have not been totally aboveboard and straightforward in their handling of this matter.

However, BCNSC's notes from the grievance relate a different version of events:

> The [Petitioner] . . . is requesting reimbursement for a SpineCor Brace, that she received at XXXXX Center . . . a Tier 2, non-contracted UM provider. The item was received on June 2, 2010, and the claim totals $4,570.00.
>
> [The Petitioner] was diagnosed with scoliosis by in network specialist . . . on May 4, 2010. The curvature in her spine is at 24 degrees, which is significant, combined with her young age. 70% of children in her age group will worsen 10 degrees or more, and 80% will progress to surgery, according to [the specialist]. That is why he wrote a prescription deeming the brace medically necessary.
>
> [The Petitioner's mother] states that her previous letter (Step One Member Grievance) focused on proving the medical necessity of her daughter's brace. She says that when she wrote the letter, she was under the assumption that there was no one "in network" that provided the Spinecor Brace. When her daughter was first diagnosed with scoliosis she did some research and came across a flexible brace that has been successful in correcting curvatures; the Spinecor Brace. She says she immediately called [BCNSC] to see if this type of brace was covered under her policy. She says she was told by a customer service representative (CSR) that the Spinecor Brace was not covered durable medical equipment (DME). She says, oddly enough, there is no record of this phone call. Secondly, she says that the denial letter claims that both [BCNSC] and XXXXX advised [XXXXX] to locate a participating provider of the Spinecor. She does not see how that information would have any bearing on the case and she was never told that such a provider existed. She asked why she was not informed of such a provider when she called . . . to inquire about the Spinecor. She says she would not choose to go out of network if she knew a covered provider existed. XXXXX indicates that they have been able to obtain the item from XXXXX Orthotics.
>
> It was verified that [XXXXX] called . . . on numerous occasions prior to providing the item, and was advised that the [Petitioner] does not have out of network benefits and that they needed to contact XXXXX for a contracted provider. There was no call found from the [Petitioner's mother] in April or May asking about the Spinecor Brace. The only call found . . . regarding the Spinecor Brace was on July 7, 2010, which is after the purchase.

> The provider request was received on July 9, 2010 and denied by our associate medical director on July 12, 2010, stating that the DME is available in network. The Step One Member Grievance was denied by a grievance coordinator stating that unauthorized and out of plan services are not a benefit. The member filed a Step Two Member Grievance on February 8, 2011. The Step Two Member Grievance was denied by the Panel members because the requested item was from an out of network provider and the member did not have prior authorization for the brace.

The Commissioner cannot resolve the factual discrepancies in this case. The Patient's Right to Independent Review Act (PRIRA) does not provide for a hearing that would be necessary to make findings of fact based on evidence such as oral statements (e.g., what was said, or not said, during a telephone conversation). Under PRIRA, the Commissioner's role is limited to determining whether the health plan administered benefits under the terms of the contract and state law.

The Commissioner concludes that the Petitioner did not have prior authorization from BCNSC to receive services at XXXXX, a non-network provider, and therefore determines that BCNSC's denial of coverage was consistent with the terms and conditions of the benefit document.

V. ORDER

The Commissioner upholds BCN Service Company's final adverse determination of February 25, 2011. BCNSC is not required to cover the Petitioner's SpineCor brace obtained from XXXXX Care Center.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.